SERFF Tracking Number:	*BALT-127340222*	*State:*	*Arkansas*
Filing Company:	*The Baltimore Life Insurance Company*	*State Tracking Number:*	*49478*
Company Tracking Number:	*6484-0611*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Application for Reinstatement*		
Project Name/Number:	*Application for Reinstatement /6484-0611*		

Filing at a Glance

Company: The Baltimore Life Insurance Company

Product Name: Application for Reinstatement	SERFF Tr Num: BALT-127340222	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 49478
Sub-TOI: L08.000 Life - Other	Co Tr Num: 6484-0611	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Lesia Braddy, Allison Thompson	Disposition Date: 08/09/2011
	Date Submitted: 08/05/2011	Disposition Status: Approved-Closed
Implementation Date Requested: 01/01/2012		Implementation Date:
State Filing Description:		

General Information

Project Name: Application for Reinstatement	Status of Filing in Domicile: Authorized
Project Number: 6484-0611	Date Approved in Domicile: 07/28/2011
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 08/09/2011
	State Status Changed: 08/09/2011
Deemer Date:	Created By: Allison Thompson
Submitted By: Allison Thompson	Corresponding Filing Tracking Number: 6484-0611

Filing Description:
Attached is Form 6484-0611(AR). This is a new form and will supersede Form 6484 1005 which was approved by your Department on January 11, 2006. The form has been revised as follows:

- Added spacing for multiple policy numbers.
- Expanded Medical Questions
- Added policy owner information
- Added section for Authorization and Disclosures
- Added section for Notification and Disclosure

SERFF Tracking Number:	*BALT-127340222*	*State:*	*Arkansas*
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• Revised agent section

This form will continue to be used to reinstate policies. Our planned implementation date is January 1, 2012.

We certify that this submission meets the provisions of Regulations 19, as well as all of the applicable requirements of the department.

Company and Contact

Filing Contact Information

Allison Thompson, Analyst	allison.thompson@baltlife.com
10075 Red Run Blvd.	410-581-6660 [Phone]
Owings Mills, MD 21117	410-581-6605 [FAX]

Filing Company Information

The Baltimore Life Insurance Company	CoCode: 61212	State of Domicile: Maryland
10075 Red Run Boulevard	Group Code: 4723	Company Type:
Owings Mills, MD 21117	Group Name:	State ID Number:
(443) 681-7586 ext. [Phone]	FEIN Number: 52-0236900	

Filing Fees

Fee Required?	Yes
Fee Amount:	$125.00
Retaliatory?	Yes
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Baltimore Life Insurance Company	$125.00	08/05/2011	50411347

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/09/2011	08/09/2011

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Project Name/Number:	*Application for Reinstatement /6484-0611*		

Disposition

Disposition Date: 08/09/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BALT-127340222*	*State:*	*Arkansas*
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Application for Reinstatement		Yes

SERFF Tracking Number:	*BALT-127340222*	*State:*	*Arkansas*
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Form Schedule

Lead Form Number: 6484-0611

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	6484-0611(AR)	Application/ Enrollment Form	Application for Reinstatement	Initial		50.000	6484-0611-ar.pdf

THE BALTIMORE LIFE INSURANCE COMPANY
10075 Red Run Boulevard • Owings Mills, MD 21117-4871 •800.628.5433 • www.baltlife.com

APPLICATION FOR REINSTATEMENT

Coverage Information

Provide Policy Number for Each Request for Reinstatement

Policy Number: _____ ☐ Policy Face Amount up to $15,000 ☐ Policy Face Amount over $15,001

Policy Number: _____ ☐ Policy Face Amount up to $15,000 ☐ Policy Face Amount over $15,001

Policy Number: _____ ☐ Policy Face Amount up to $15,000 ☐ Policy Face Amount over $15,001

Proposed Insured Information

Proposed Insured	Social Security Number	Sex	Date of Birth Mo/Day/Year	Height	Weight	Weight Change in Past Year	Occupation
Primary Insured							
Additional Insured							
Child							
Child							
Child							

Has Any Proposed Insured**:**	YES	NO
a. Had any application for life or health insurance declined, postponed, or modified in any way, or been refused issue, renewal, or reinstatement?	☐	☐
b. Within the past five years used marijuana, narcotics, hallucinogenics, barbiturates, amphetamines, tranquilizers, except as prescribed by a physician, or been convicted for possession or sale of any of the above?	☐	☐
c. Within the last two years, been refused a driver's license, had a license revoked or suspended, or had three or more moving violations or accidents?	☐	☐
d. Ever applied for or received a pension, disability payment/compensation or benefit due to illness or injury?	☐	☐
e. Currently bedridden, confined to a wheelchair due to chronic illness, in a hospital, living in a nursing home, hospice, assisted living facility or long-term care facility or using oxygen or has a doctor recommended using oxygen or dialysis?	☐	☐
f. Been diagnosed as having a terminal medical condition that is expected to result in death within the next 12 months?	☐	☐
g. Ever been diagnosed with or treated (including medication) by a licensed medical practitioner, or hospitalized for Acquired Immunodeficiency syndrome ("AIDS"), AIDS-related complex, human immunodeficiency virus (HIV), Alzheimer's/Dementia, permanent memory loss, mental impairment, or schizophrenia?	☐	☐
h. Ever used any tobacco or nicotine products? If yes, list type, amount used, and length of time used._____ If no longer using tobacco products, also list the date stopped._____	☐	☐

Provide full details of any "YES" answers above. This includes full details for each question including nature of illness or injury, number of attacks duration, severity, treatment results, name and address of doctors, hospitals or clinics involved. Please also include any prescription medication information.

Name of Proposed Insured	Question Number	Date	Details

Medical Information

Name & address of physician with most up-to-date and comprehensive records; include date of, reason for, and result of last visit.

Name of Proposed Insured	Date	Name of Medical Professional	History

In the past 5 years has any proposed insured ever been diagnosed with or treated (including medication) by a licensed medical practitioner, or hospitalized for any of the following:	YES	NO
1. Any chronic or progressive disease of the heart, kidneys, liver, lung (exclude asthma with less than weekly episodes), pancreas, or bone marrow?	☐	☐
2. Heart attack, congestive heart failure, angina, stroke, transient ischemic attack (TIA), or any other condition of the heart or arteries, have you undergone angioplasty or bypass surgery, used a pacemaker or defibrillator?	☐	☐
3. Uncontrolled high blood pressure, uncontrolled diabetes or blood sugars, (except during a pregnancy), diabetic coma or any diabetes requiring the use of insulin, or other endocrine disorder?	☐	☐
4. Stroke, any paralysis, Parkinson's, mental retardation, psychosis, suicide attempt, disease or disorder of the brain, bi-polar or any condition affecting or relating to circulation to the brain?	☐	☐
5. Any organ (except cornea), bone marrow, or stem cell transplant recommended, performed, or been placed on a transplant waiting list?	☐	☐

Provide full details of any "YES" answers above. This includes full details for each question including nature of illness or injury, number of attacks duration, severity, treatment results, name and address of doctors, hospitals or clinics involved. Please also include any prescription medication information.

Name of Proposed Insured	Question Number	Date	Details

Policy Face Amounts Over $15,001 Continue to Medical Questions 6 to 14	
Within the last 5 years has any proposed insured ever been diagnosed with or treated (including medication) by a licensed medical practitioner, or hospitalized for:	YES NO
6. Disease or disorder of heart or blood vessels, any shortness of breath, chest pains, swelling of ankles, high blood pressure, rheumatic fever, anemia, or other blood or circulatory disorder?	☐ ☐
7. Disease or disorder of brain or nervous system, paralysis, dizziness, weakness or numbness, fainting spells, convulsions, epilepsy, hallucinations, nervousness, or mental disorder?	☐ ☐
8. Asthma, hay fever, chronic cough, bronchitis, emphysema, spitting blood, tuberculosis, chronic obstructive pulmonary disease or any other disorder of the lungs or respiratory system?	☐ ☐
9. Hernia, gallbladder disorder, ulcers, colitis, disease or disorder of stomach, intestines, or other digestive complaints?	☐ ☐
10. Jaundice, disease or disorder of kidneys, liver, bladder, male or female reproductive organs, sugar, albumin, blood or pus in the urine?	☐ ☐
11. Cysts, tumor, cancer, disease or disorder of skin or breast?	☐ ☐
12. Any form of arthritis, rheumatism, bone, joint, back disorder, lameness, loss of limb, or deformity?	☐ ☐
13. Any defect of sight, speech, hearing or disorder of the nose, throat or discharge from ears?	☐ ☐
14. Alcoholism, narcotic addiction, or drug habituation, mental or physical disorder not listed?	☐ ☐

Provide full details of any "YES" answers above. This includes full details for each question including nature of illness or injury, number of attacks duration, severity, treatment results, name and address of doctors, hospitals or clinics involved. Please also include any prescription medication information.

Name of Proposed Insured	Question Number	Date	Details

Policy Owner Information

Last Name	First Name		MI
Street Address	City	State	Zip Code
State	Telephone Number		
Social Security Number	Email Address		

Authorization and Disclosures

I understand that the policy will not be reinstated until The Baltimore Life Insurance Company ("the Company") has received the full amount of premiums in arrears and has approved this application at it's home office. I understand that should death occur while this application is under review there is no insurance coverage and no benefits will be paid. I also understand that if the policy is reinstated, such reinstatement will be conditioned upon the correctness of the answers to the above questions.

The statements made in this application are complete, true and correctly recorded. These statements are offered to the Company as an inducement to reinstate the policy listed on this application. I agree that a copy of this application will form a part of any policy issued. No agent can pass on insurability or modify any policy reinstated by the Company. If this application is not approved, the Owner will accept the return of any amount paid in connection with this application without interest. Reinstatement of the policy will be contestable for two (2) years from the effective date of reinstatement for fraud or misrepresentation of any material fact in this application. Notwithstanding the prior sentence, the Company can contest any benefits that provide disability coverage.

I hereby acknowledge that I have received and read the attached MIB,Inc. Disclosure and Fair Credit Reporting Statements. I authorize any physician or other medical professional, prescription record service, any hospital or other medical care institution, the MIB,Inc, any consumer reporting agency, any insurance company, and any other organization to release certain information to The Baltimore Life Insurance Company, its reinsurer(s) and any consumer reporting agency acting on the Company's behalf. The information authorized for release is any record or other knowledge as to the health, medical treatment or advice, and other insurance coverage of myself and any children who are to be insured. I agree that this authorization to obtain medical information shall be valid for a period of two years and six months from the date it is signed. A photographic copy of this authorization shall be as valid as the original. A copy of this authorization form or any Investigative Consumer Report may be obtained upon request. The Company reserves the right to require a medical examination. I understand I have the right to recind this authorization at any time by writing the Company.

IMPORTANT TAX NOTICE FOR POLICY OWNER: Under federal Tax law, the Company is required to ask you to certify your correct Taxpayer Identification Number (TIN), and to include it in any reports of taxable income it makes to the IRS.

CERTIFICATION: Under penalties of perjury, I certify that: 1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2) I am not subject to backup withholding under provisions of section 3406(a)(1)(c) of the Internal Revenue Code because a) I am exempt from backup withholding, or b) I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or c) the IRS has notified me that I am no longer subject to backup withholding, and 3) I am a US person (including a US resident alien).

The Internal Revenue Service does not require your consent to any provisions to this document other than the certification to avoid backup withholding.

WARNING: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have had read to me all of the questions and answers contained in this application. This application is complete and true to the best of my knowledge and belief. I understand that no agent is authorized to advise me that any inaccurate answer is acceptable.

NOTE: SIGNATURES ARE REQUIRED TO REINSTATE POLICY

Signature of Proposed Insured	Date
Signature of Proposed Additional Insured	Date
Signature of Child (if over age 18) Date	Signature of Child (if over age 18) Date
Signature of Owner (if other than Insured) Date	Signature of Payor (If Other Than Proposed Insured Or Owner) Date

This Section To Be Completed By Agent Only

I certify that I have asked the person proposed for coverage all of the questions contained in this application and have accurately recorded on this application the information supplied by the persons proposed for coverage.

a. Did you verify the identity of the applicant by viewing their driver's license or other government issued form of identification? ..... ☐ Yes ☐ No

b. Do you believe the answers on this reinstatement application form are complete and they correctly reflect the present insurability of the risk? ..... ☐ Yes ☐ No

Agent Comments

☐ **Reinstatement by Re-Date**

_____

_____

_____

_____

_____

_____

I certify that I am unaware of any additional information that might affect the Company's underwriting decision and that the above statements and responses are true and accurate.

(X) _____ _____ _____ _____

Writing Agent Signature | Printed Name | Date | Agent Number

NOTIFICATION AND DISCLOSURE

IMPORTANT TAX NOTICE FOR POLICYOWNER

Under federal tax law, the Company is required to ask you to certify your correct Taxpayer Identification Number (TIN), and to include it in any reports of taxable income it makes to the IRS.

FAIR CREDIT REPORTING ACT NOTICE

As part of our evaluation of your application for insurance, an investigative consumer report may be prepared, whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related directly or indirectly to your sexual orientation.

Upon your written request, and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

MIB, INC PRE-NOTICE

Information regarding your insurability will be treated as confidential. Baltimore Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB,Inc member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB,Inc, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, the MIB,Inc will arrange disclosure of any information in your file. Please contact the MIB,Inc. at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB,Inc.'s file, you may contact the MIB,Inc and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB,Inc's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Baltimore Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about the MIB,Inc may be obtained on its website at www.mib.com.

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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
ar-read.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: n/a
Comments:

THE BALTIMORE LIFE INSURANCE COMPANY
10075 Red Run Boulevard • P.O. Box 1060 • Owings Mills, Maryland 21117-5060
(410) 581-6600

CERTIFICATION OF READABILITY

This is to certify that Form 6484-0611(AR) meets the minimum reading ease score for the state of Arkansas on the Flesch reading ease test.

Vice President  July 25, 2011
Date